DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from December 12, 2007 through December 13, 2007. The survey was conducted using the fundamental survey process. A random sample of two clients was selected from a residential population of two males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at one day program, interviews and a review of records, including unusual incident reports.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility's governing body provided general operating directions except for the deficient practices detailed below. The finding includes I. The Governing Body failed to provide continous maintenance and repair of the facility's van. [See W322] II. The governing body failed to ensure the implementation of its medication destruction policy. Observation of the evening medication administration on December 12, 2007 beginning at 5:26 PM revealed Client #1 received medications including Phenobarbital, Depakote, and Topamax. During the observation, Client #1	W 104	W104 1. See Response for w322 2. RN will retrain the medication nurse on properly disposing of medications.	1-30-08 1-30-08

RECEIVED
DEPARTMENT OF HEALTH
REGULATION
HEALTH ADMINISTRATION
2007 JAN 23 P 4:34

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anita N. Wilson
TITLE: Director of Residential Serv.
(X6) DATE: 1/23/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 104	Continued From page 1 was observed to drop one of the Depakote pills from his mouth. The nurse was observed to re-administer another Depakote to the client. Continued observation of the nurse revealed the nurse disposed of the dropped Depakote by crushing it and placing it in the sharps container located in Client #2's bedroom. Review of the facility's policy for disposal of medication revealed that medications should be disposed of by crushing them and/or melting them completely and flushing down the drain. At the time of the survey, the facility failed to ensure the dropped Depakote was disposed of in accordance with facility policy.	W 104		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for one of the two clients (Client #1) included in the sample. The finding includes:	W 124		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 124	Continued From page 2 Observation of the evening medication administration on December 12, 2007 beginning at 5:26 PM revealed Client #1 received medications including Phenobarbital, Depakote, and Topomax. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the client's seizure disorder. Subsequent to the medication administration observation, the December 2007 Physician's Orders (POS) were reviewed and reflected that client #1 was prescribed Naltrexone Hydrochloride to address self injurious behaviors. This corroborated information provided by the House Manager (HM) on December 12, 2007 at 12:55 PM, and reflected that the medication is used to control behaviors used in conjunction with a Behavior Support Plan (BSP). This interview with the HM also revealed that Client #1 was not capable of giving informed consent for the use of his medications and habilitation service needs. The HM also indicated that Client #1 has involved family members but did not have a legal guardian appointed. Review of Client #1's records on December 13, 2007 at approximately 3:30 PM revealed the client's psychological assessment dated June 2, 2007. According to the assessment, Client #1 "is not able to make independent decisions concerning his residential or day placements, treatment plans or financial affairs. He lacks the cognitive skills necessary to understand the implications of such decisions and therefore cannot give his informed consent." At the time of the survey, the facility failed to provide evidence that Client #1's treatment needs, including the benefits and potential side effects associated with	W 124	W124 Client # 1's sister supports him in making important decisions. She has had his medication regimen reviewed with her and has agreed to sign a consent for the regimen. Her signature will be obtained by 1-30-08.	1-30-08

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 124	Continued From page 3 the medications, and the right to refuse treatment, had been explained to him and a legally authorized representative.	W 124		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that family members were notified promptly of significant incidents for one of the two clients (Client #1) included in the sample. The finding includes: Review of the facility's investigative reports on December 12, 2007, beginning at 2:10 PM revealed the following: On February 20, 2007, staff reported that blood was observed on Client #1's sock after returning from the day program. The report also indicated that the client's foot had been caught in the van lift. The residential nurse assessed the client and sent the client to the emergency room. The client was subsequently diagnosed with a fractured right toe. It should be noted that interview with the HM and Qualified Mental Retardation Professional (QMRP) on December 12, 2007, revealed the aforementioned incident was categorized as neglect. Additionally, interview with the HM on December 12, 2007 at 12:55 PM revealed Client	W 148	W148 The QMRP spoke with the sister of client #1 about the incident, but did not document the conversation in her notes. In the future, the QMRP will document such conversations in her notes. The sister was satisfied with the way MTS handled the incident. She raised no concerns on issues.	1-18-08 1-5-08

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 148	Continued From page 4 #1 had involved family members, however, there was no evidence provided to substantiate that Client #1's family was notified of the aforementioned incident.	W 148		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement policies that ensured the health and safety of one of the two clients (Client #1) included in the sample. The finding includes: The facility failed to ensure its incident management policy was developed and/or implemented in accordance with the federal regulations. A. Interview was conducted with the facility's House Manager (HM) on December 12, 2007, at 1:29 PM to ascertain information about the facility's incident management system. According to the interview, if staff observed, discovered, or was informed of an incident, the information about the incident was verbally reported to the HM, who in turn, would report that information to the Incident Management Coordinator (IMC). Once the information was reported to the IMC, the IMC entered the information into an incident reporting system operated by the Department on Disability Services (DDS). The IMC was responsible for making all written notifications. It	W 149	W149 The QMRP will retrain all staff on incident reporting and proper documentation by All new staff will receive training via the QMRP within their first work week as a part of their in-home orientation.	1-30-08 1-30-08

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 5 was also noted that all required verbal notifications, including notifications to the family or guardian, were made by the HM within 24 hours. The HM also revealed that the Department of Health was not verbally notified but was notified in writing by the IMC within five working days. The interview with the HM also revealed that the facility stopped using hand written incident report forms approximately two years ago; at that time, the system described above (IMC documenting incidents) was initiated. The HM also revealed a new incident reporting system was developed that included requirements for staff to document incidents on an incident report form. According to the HM staff were in-serviced on that system in October 2007. Individual interviews were conducted with two staff on December 12, 2007 at 1:52 PM and 1:55 PM respectively, to ascertain if they were aware of the new system. According to the interviews, the staff were not aware of the required documentation form (Incident Report Form). B. Review of the facility's investigative reports on December 12, 2007, beginning at 2:10 PM revealed the following: On February 20, 2007, staff reported that blood was observed on Client #1's sock after returning from the day program. The report further revealed that the client's foot had been caught in the van lift. The residential nurse assessed the client and sent the client to the emergency room. The client was subsequently diagnosed with a fractured right toe. It should be noted that interview with the HM and Qualified Mental Retardation Professional (QMRP) on December	W 149	B. The incident cited was reported to the Department of Health. An incident report was sent. In the future, MTS staff will indicate on the incident reporting form that DOH was contacted. The QMRP will review all incident reports before they are submitted to insure the above.	1-30-08 1-30-08

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 149	Continued From page 6 12, 2007, revealed that the aforementioned incident was categorized as neglect. Additionally, there was no evidence that the incident was reported to the Department of Health (DOH). C. The facility's incident management and reporting policy (revised1/15/06) was reviewed on December 13, 2007, and revealed the following information: - The Program Director/QMRP is to ensure timely notification of any and all allegations of abuse, neglect or mistreatment to the appropriate authorities. In accordance with our regulatory requirement, any such allegations should be reported within 24 hours of the initial verbal report. The agencies to be notified include DDS, DOH, the Commission on Health Care Finance and other agencies depending on the nature and severity of the occurrence. - The QMRP was responsible for recording incidents on an "Unusual Occurrence/Incident Form." - The QMRP was responsible for contacting the client's family within 48 hours of the incident. Note: Interview with the HM on December 12, 2007 at 12:55 PM revealed Client #1 had involved family members. At the time of the survey, incident reports were not available for review. Additionally, the facility failed to provide evidence that the policy was written in accordance with the regulations to make certain notifications were made as required. (See also W148 and W153).	W 149	C. MTS' incident management guide clearly indicates DOH as an entity to be contacted and faxed an incident report copy. (See attachment)	1-20-08
W 153	483.420(d)(2) STAFF TREATMENT OF	W 153		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 153	Continued From page 7 CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all allegations of neglect and injuries of unknown origin were reported immediately to the administrator or to other officials in accordance with state law [22 DCMR Chapter 35 3519.10] through established procedures for one of the two clients (Client #1) included in the sample. The finding includes: Review of the facility's investigative reports on December 12, 2007, beginning at 2:10 PM revealed the following: On February 20, 2007, staff reported that blood was observed on Client #1's sock after returning from the day program. The report further revealed that the client's foot had been caught in the van lift. The residential nurse assessed the client and sent the client to the emergency room. The client was subsequently diagnosed with a fractured right toe. It should be noted that interview with the HM and Qualified Mental Retardation Professional (QMRP) on December 12, 2007, revealed the aforementioned incident was categorized as neglect.	W 153		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 153	Continued From page 8 Interview with the Qualified Mental Retardation Professional (QMRP) on December 13, 2007 was conducted to ascertain if there was an incident report for the aforementioned incident. At the time of the survey, no incident report was provided for review. Therefore, there was no evidence that notifications were made to the facility's administrator and the Department of Health (DOH) as required.	W 153	W153 A copy of the incident report cited has been placed in the client records. The QMRP will routinely follow up with the IMC to ensure that final versions of the incident reports are returned to the home and appropriately filed on a routine basis. The QMRP will audit the records monthly to insure routine compliance.	1-20-08 1-30-08
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all allegations of abuse and neglect and injuries of unknown origin were thoroughly investigated for one of the two clients (Client #1) a included in the sample. The finding includes: Review of the facility's investigative reports on December 12, 2007 beginning at 2:10 PM revealed the following: On February 20, 2007, staff reported that blood was observed on Client #1's sock after returning from the day program. The report further revealed that the client's foot had been caught in the van lift. The residential nurse assessed the client and sent the client to the emergency room. The client was subsequently diagnosed with a fractured right toe. It should be noted that interview with the HM and Qualified Mental Retardation Professional (QMRP) on December	W 154		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 154	Continued From page 9 12, 2007, revealed that the aforementioned incident was categorized as neglect. Review of the corresponding investigation for the incident (not dated) and interview with the QMRP on December 12, 2007 revealed that there was two staff on duty and present at the time of the incident. However, the investigative report revealed evidence of only one direct care staff member being interviewed (the van driver). Follow-up interview was conducted with the QMRP to ascertain if the second person was interviewed at the time of the investigation to disclose any information regarding the incident. The QMRP revealed that the second staff person was not interviewed and was no longer employed by the facility.	W 154	W154 The QMRP is incorrectly quoted. The second staff member was interviewed but stated she did not see what happened. She was not asked to write a brief statement to that effect which was an error. The residential Director will retrain the QMRP to insure that all parties who are at the scene of an incident are interviewed and statements are taken regardless of what they did or did not see or hear. The primary staff person provided the key facts, which are not in dispute. MTS took appropriate action based on that.	1-30-08 1-5-08
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure required investigations were reviewed by the administrator or designee within five working days, for one of the two clients (Client #1) included in the sample. The finding includes: Review of the facility's investigative reports on December 12, 2007, beginning at 2:10 PM revealed the following:	W 156		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 156	Continued From page 10 On February 20, 2007, staff reported that blood was observed on Client #1's sock after returning from the day program. The report further revealed that the client's foot had been caught in the van lift. The residential nurse assessed the client and sent the client to the emergency room. The client was subsequently diagnosed with a fractured right toe. It should be noted that interview with the HM and Qualified Mental Retardation Professional (QMRP) on December 12, 2007, revealed that the aforementioned incident was categorized as neglect. Review of the corresponding investigation for the incident (not dated) and interview with the QMRP on December 13, 2007 failed to provide evidence that the investigation was reviewed by the administrator or designee as required. Blank spaces were observed for the incident manager and the administrator.	W 156	W156 The investigation copy presented for the survey did not have the IMC or Residential Director's signatures. The QMRP failed to obtain a copy of the final signed document from the main office to replace the unsigned copy in the record. The document was properly reviewed by the IMC and Residential Director. (see attachment) and a signed copy is now in the home.	1-20-08
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The findings include: 1. The facility failed to provide evidence that the	W 189	W189 1. Satff will be retrained on the incident reporting policy by the QMRP and by 1-30-08.	1-30-08

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	Continued From page 11 staff were effectively trained on the facility's Incident Management policy. (See W149, I) 2. The facility failed to provide evidence that nursing staff were effectively trained on the medication disposal policy. (See W104)	W 189	2. The lead RN will retrain the medication nurses on MTS' policy on the disposal of medications by 1-30-08	1-30-08
W 209	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that Client #2 participated in his annual Individual Support Planning (ISP) meeting. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on December 13, 2007 revealed Client #2 participated in his Individual Support Plan (ISP) meeting. However review of the attendance record for the annual meeting dated July 6, 2007 did not include Client #2's name.	W 209	W209 Client #2 cannot sign his name but is assisted in making his "mark" with support staff then writing in his name. This did not occur in the last meeting although he was present. This was an oversight not caught in the audit process. The QMRP will insure that client #2 "signs" in the future, and a late entry will be done to verify his attendance and participation in the last meeting. The residential Director will review all ISPs before they are submitted.	1-30-08
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure Client #1 received a	W 214		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued From page 12 comprehensive psychiatric assessment. The finding includes: Observation of the evening medication administration on December 12, 2007 beginning at 5:26 PM revealed Client #1 received medications including Phenobarbital, Depakote, and Topomax. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the client's seizure disorder. Subsequent to the medication administration observation, the December 2007 Physician's Orders (POS) were reviewed and reflected that client #1 was prescribed Naltrexone Hydrochloride to address self injurious behaviors. This corroborated information provided by the House Manager (HM) on December 12, 2007 at 12:55 PM, and reflected that the medication is used to control behaviors used in conjunction with a Behavior Support Plan (BSP). An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on December 13, 2007 to ascertain if Client #1 had a comprehensive psychiatric assessment to justify the use of the behavior modification drugs and his corresponding psychiatric diagnoses (Intermittent Explosive Disorder). At the time of the survey, the facility lacked evidence that Client #1 received a comprehensive psychiatric assessment.	W 214	W214 A full psychiatric assessment will be completed by 1-30-08 The QMRp and lead RN will audit the medical records no less than quarterly to ensure all assessments are current.	1-30-08
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.	W 263		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 13 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's specially-constituted committee (Human Rights Committee, (HRC)) failed to ensure that restrictive programs were used only with written consents, for one of the two clients (Client #1) included in the sample. The finding includes: Observation of the evening medication administration on December 12, 2007 beginning at 5:26 PM revealed Client #1 received medications including Phenobarbital, Depakote, and Topomax. Interview with the medication nurse during the medication administration, revealed the aforementioned medications were used to address the client's seizure disorder. Subsequent to the medication administration observation, the December 2007 Physician's Orders (POS) were reviewed and reflected that client #1 was prescribed Naltrexone Hydrochloride to address self injurious behaviors. This corroborated information provided by the House Manager (HM) on December 12, 2007 at 12:55 PM, and reflected that the medication is used to control behaviors used in conjunction with a Behavior Support Plan (BSP). The interview with the HM on December 12, 2007 at 12:55 PM also revealed that Client #1 was not capable of giving informed consent for the use of his medications and habilitation service needs. The HM further revealed that Client #1 had involved family members but did not have a legal guardian.	W 263	W263 See Responses for W124	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 263	Continued From page 14 Review of Client #1's records on December 13, 2007 at approximately 3:30 PM revealed the client's psychological assessment dated June 2, 2007. According to the assessment, Client #1 "is not able to make independent decisions concerning his residential or day placements, treatment plans or financial affairs. He lacks the cognitive skills necessary to understand the implications of such decisions and therefore cannot give his informed consent." Review of the client's BSP on December 13, 2007 at approximately 3:35 PM revealed the plan included the use of a psychotropic medication (Revia). At the time of the survey, the facility failed to ensure appropriate consents were obtained prior to implementation of this restrictive practice.	W 263		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure general and preventive care was provided for one of the two clients (Client #2) included in the sample. The findings include: 1. Review of Client #2's medical record on December 13, 2007 at 1:47 PM revealed Client #2 was seen by a Physical Therapist (PT)on May 31, 2007. The consultation form revealed that Client #2 was to return for follow-up services in six weeks. However, the client's record lacked evidence that the client was seen for follow-up services until November 5, 2007 (approximately	W 322	W322 1. PT recommended Botox injections for the wrists and fingers for client #2. Nursing and QMRP scheduled the appointment. At the time of the appointment, the homes's vehicle was inoperable as indicated by the surveyor. Also as indicated, MTS' QMRP and Nursing made an alternative arrangement for transportation via one of the approved medicaid provider vendors. The vendor failed to pick up client #2 and did not notify MTS of any issues it was having with the appointment. This is a common problem with transportation vendors and the reason the MTM contract was developed. MTS rescheduled the appointment for the first available date but that happened to be in November.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/10/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 15 six months later). An interview was conducted with the House Manager and the Qualified Mental Retardation Professional (QMRP) on December 13, 2007 at 3:30 PM to ascertain the reason for the untimely follow-up services. The interview revealed that the facility's van had been inoperable at the time of the follow-up visit (June 2007) and transportation was arranged with a local vendor; however, the vendor failed to pick the client up for the appointment. 2. On December 13, 2007 at 2:09 PM , Client #2's medical record was reviewed and revealed he was seen by a Cardiologist on February 7, 2007. The consult form also indicated that the client had some blood chemistries that were abnormal and recommended that they be addressed by the client's Primary Care Physician (PCP). The laboratory results that were collected on January 23, 2007 revealed the following: Glucose 325 H reference range (74 - 105) Monos 15.3 H reference range (4 - 13.0) SGOT 72 H reference range (15 - 37) SGPT 92 H reference range (28 - 77) According to a physician's note dated March 6, 2007, the PCP noted the aforementioned lab results, however, there was no evidence that the abnormal results were addressed or managed.	W 322	Client #2 has received the Botox injections and has benefitted from them. MTS has a back up van that is wheelchair accessible at this point which will elliminate the need to use transportation vendors for future emergencies. 2. Nursing discussed the abnormal values with the PCP but both failed to write notes outlining whether they are significant and require further follow up. The lead LNP will contact the PCP to follow up further and will write a detailed note about the outcomes of the discussion. The QMRP will review the medical records to audit for such concerns and alert the lead RN in their routine monthly meetings.	1-18-08 1-18-08 1-20-08 1-30-08

PRINTED: 01/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS A relicensure survey was conducted from December 12, 2007 through December 13, 2007. A random sample of two residents was selected from a residential population of two males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at one day program, interviews and a review of records, including unusual incident reports.	R 000		
R 124	4701.4 BACKGROUND CHECK REQUIREMENT The facility shall obtain a criminal background check from the Metropolitan Police Department, from the U.S. Department of Justice, or from a private agency. This Statute is not met as evidenced by: Based on interview and review of the records the GHMRP failed to ensure all direct care staff had obtained a criminal background check from the Metropolitan Police Department, from the U.S. Department of Justice, or from a private agency. The finding includes: Review of the GHMRP's personnel files on December 13, 2007, revealed the GHMRP failed to provide evidence that police clearances were on file for one direct care staff and one administrative staff.	R 124	R 124 Attached are the copies of the criminal checks for staff (2) cited. MTS completed criminal background checks for all new staff prior to making final decisions to hire. Personnel records are audited at minimum quarterly (main office files) to insure all are full and complete and to proactively notify staff of pending issues.	1-20-08 1-20-08

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATE FORM 6899 17OZ11 If continuation sheet 1 of 1

PRINTED: 01/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS An annual licensure survey was conducted from December 12, 2007 through December 13, 2007. A random sample of two residents was selected from a residential population of two males with mental retardation and other disabilities. The survey findings were based on observations in the group home and at one day program, interviews and a review of records, including unusual incident reports.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the GHMRP failed to ensure the interior of the facility was maintained in a safe manner. The findings include: Observation during the environmental walk through on December 16, 2007 and interview with the Qualified Mental Retardation Professional (QMRP) revealed the following: 1. The bottom grill of the refrigerator was missing. 2. The back door was not properly affixed to the door frame, and the back storm door did not close securely.	I 090	3504.1 MTS is relocating the individuals supported at 45th street to a new home in better overall condition. The move will occur by 2/15/08	2-15-08

PRINTED: 01/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 206	Continued From page 1	I 206		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification that documented a health inventory had been performed and that the employee's health status would allow him or her to perform the required duties. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the GHMRP's personnel files on December 13, 2007, revealed the GHMRP failed to provide evidence that current health certificates were on file for two direct care staff the QMRP, one nurse and five consultants.	I 206	3509.6 All of the staff and consultants have been notified and must submit updated health certificates by 2-20-08. Failure to comply will result in removal from the work schedule and possible further action.	2-20-08
I 271	3513.1(b) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (b) Personnel records for all staff including job descriptions either at the GHMRP or in a central	I 271	3513.1 (b) MTS has personnel files for all of its nursing personnel and the podiatrist it routinely uses. A number of nurses have file deficiencies that are being addressed currently. All nursing personnel files will be full and complete by	2-20-08

PRINTED: 01/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 271	Continued From page 2 office and made available upon request; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence that it maintained personnel records for all of its staff. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the GHMRP personnel records on December 13, 2007 revealed that there were missing personnel records for its nursing staff and for the Podiatrist.	I 271		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health, Intermediate Care Facilities Division was immediately notified of unusual incidents that substantially interfered with a resident's health, or that written notification was forwarded within 24 hours of occurrence for one of the two residents (Resident #1) that resided in the facility.	I 379		

PRINTED: 01/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 379	Continued From page 3 The finding includes: Review of the facility's investigation reports on December 12, 2007, beginning at 2:10 PM revealed the following: On February 20, 2007, staff reported that blood was observed on Resident #1's sock after returning from the day program. The report further revealed that the resident's foot had been caught in the van lift. The residential nurse assessed the resident and sent the resident to the emergency room. The resident was subsequently diagnosed with a fractured right toe. It should be noted that interview with the HM and Qualified Mental Retardation Professional (QMRP) on December 12, 2007, revealed the aforementioned incident was categorized as neglect. Interview with the Qualified Mental Retardation Professional (QMRP) on December 13, 2007 was conducted to ascertain if there was an incident report for the aforementioned incident. At the time of the survey, no incident report was provided for review. Therefore, there was no evidence that notificatifications were made to the Department of Health (DOH) as required.	I 379	3519.10 The QMRP spoke with the sister of client #1 about the incident, but did not document the conversation in her notes. In the future, the QMRP will document such conversations in her notes. The sister was satisfied with the way MTS handled the incident. She raised no concerns on issues. The QMRP will retrain all staff on incident reporting and proper documentation by All new staff will receive training via the QMRP within their first work week as a part of their in-home orientation. The incident cited was reported to the Department of Health. An incident report was sent. In the future, MTS staff will indicate on the incident reporting form that DOH was contacted. The QMRP will review all incident reports before they are submitted to insure the above. MTS' incident management guide clearly indicates DOH as an entity to be contacted and faxed an incident report copy. (See attachment)	1-18-08 1-30-08 1-30-08 1-20-08
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by:	I 401		

PRINTED: 01/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I401	Continued From page 4 Based on interview and record review, the GHMRP failed to ensure general and preventive care for one of the two residents (Resident #2) included in the sample. The findings include: 1. Review of Resident #2' s medical record on December 13, 2007 at 1:47 PM revealed Resident #2 was seen by a Physical Therapist (PT)on May 31, 2007. The consultation form revealed that Resident #2 was to return for follow-up services in six weeks. Continued review of the resident's record revealed the resident did not return for follow-up services until November 5, 2007 (approximately six months later). An interview was conducted with the House Manager and the Qualified Mental Retardation Professional (QMRP) on December 13, 2007 at 3:30 PM to ascertain the reason for the untimely follow-up services. The interview revealed that the facility's van had been inoperable at the time of the follow-up visit (June 2007) and transportation was arranged with a local vendor; however, the vendor failed to pick the client up for the appointment. 2. On December 13, 2007 at 2:09 PM, Client #2's medical record was reviewed and revealed he was seen by a Cardiologist on February 7, 2007. The consult form also indicated that the client had some blood chemistries that were abnormal and recommended that they be addressed by the client's Primary Care Physician (PCP). The laboratory results that were collected on January 23, 2007 revealed the following:	I401	3520.3 PT recommended Botox injections for the wrists and fingers for client #2. Nursing and QMRP scheduled the appointment. At the time of the appointment, the homes's vehicle was inoperable as indicated by the surveyor. Also as indicated, MTS' QMRP and Nursing made an alternative arrangement for transportation via one of the approved medicaid provider vendors. The vendor failed to pick up client #2 and did not notify MTS of any issues it was having with the appointment. This is a common problem with transportation vendors and the reason the MTM contract was developed. MTS rescheduled the appointment for the first available date but that happened to be in November. Client #2 has received the Botox injections and has benefitted from them. MTS has a back up van that is wheelchair accessible at this point which will elliminate the need to use transportation vendors for future emergencies.	

PRINTED: 01/10/2008
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G005	A. BUILDING _____ B. WING _____	12/13/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	1044 45TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 401	Continued From page 5 Glucose 325 H reference range (74 - 105) Monos 15.3 H reference range (4 - 13.0) SGOT 72 H reference range (15 - 37) SGPT 92 H reference range (28 - 77) According to a physician's note dated March 6, 2007, the PCP noted the aforementioned lab results, however, there was no evidence that the abnormal results were addressed or managed.	I 401	Nursing discussed the abnormal values with the PCP but both failed to write notes outlining whether they are significant and require further follow up. The lead LNP will contact the PCP to follow up further and will write a detailed note about the outcomes of the discussion. The QMRP will review the medical records to audit for such concerns and alert the lead RN in their routine monthly meetings.	1-18-08
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRF failed to ensure the protections of each resident's rights. The findings include: [See Federal Deficiency Report W124 and W263]	I 500	3523.1 Client # 1's sister supports him in making important decisions. She has had his medication regimen reviewed with her and has agreed to sign a consent for the regimen. Her signature will be obtained by 1-30-08.	1-30-08